

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

03082

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
City or town Berlin R. 2D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Charissa Elizabeth Bishop

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife William Bishop

7. Birth date of deceased (mo., day, yr.) July 6, 1884 6.(c) If alive, give age 80 years

8. AGE: Years 61 Months 7 Days 22 If less than one day
hrs. min.

9. Birthplace Berlin Wor. Co. md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Frederick L. Hammond

13. Birthplace Berlin md. R. 2D

14. Maiden name Berna Baker

15. Birthplace Maryland

16. Informant Dr. William Bishop

Address Berlin md R 2D

17. Burial Date thereof 3/3/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Reverieside

Location Berlin md (Libertown)

18. Funeral director Berna A. Bishop

Address Berlin md

19. 3-3 1946 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 1946 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to 1946
and that I last saw her alive on Feb 28 1946

Immediate cause of death

Due to Cerebral

Hemorrhage

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R. Saw M. D. or other

Address Berlin md Date signed 3-2-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 7 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

CERTIFICATE OF DEATH

Reg. Dist. No.

03083 351

1. PLACE OF DEATH:

County WorcesterCity or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louis H. Bowdle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

February 12, 1901

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

4518

.....hrs.

.....min.

9. Birthplace

Caroline County, Maryland
(Town, county, and state)

10. Usual occupation

Fireman

11. Industry or business

Pennsylvania Railroad Co.

FATHER

12. Name

Daniel Bowdle

13. Birthplace

Caroline County, Maryland

MOTHER

14. Maiden name

Addie Henry

15. Birthplace

Dorchester County, Maryland

16. Informant

Clarence E. Bowdle

Address

Federalburg, Maryland, R.F.D.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 2, 1946
(month) (day) (year)

Cemetery or crematory

Wick Crest Cemetery

Location

Federalburg, Maryland

18. Funeral director

J. J. Grafton and Son

Address

Federalburg, Maryland

19.

(Date rec'd by registrar)

3/31/46Reddy Smith
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Caroline

City or town

Federalburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Leontia Road

(If rural, give LOCATION)

2. (a) If veteran, name war

.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 30th 1946 2:20P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19.....

to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Accident

DURATION

Due to

Burned completely Immediate

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

AccidentDate of March 30, 1946

Where did injury occur?

HomeWPAMed

(City or town)

(County)

(State)

Where did injury occur? Home, farm, industry, public place (where?)

HomeTrain hit truck

Injured at work?

Yes

23. SIGNATURE

F. S. McNeil, M.D.

M. D. or other

Address

Berlin Md

Date signed

3/31/46

RECEIVED
APR 3 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17003

CERTIFICATE OF DEATH

03084



Reg. Dist. No. 355

1. PLACE OF DEATH:

County ShaweeCity or town Shawee

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? AccidentHospital, institution, or street address where death occurred: noHow long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no ✓

3. (a) FULL NAME

Mr Lester Bowen

3. (b) Social Security Number

216-09-58764. Sex male5. Color or race col'd

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Mamie Bowenyes no7. Birth date of deceased (mo., day, yr.) June 16 - 18928. AGE: Years 57 Months 8 Days 26 If less than one day

.....hrs.min.

9. Birthplace Berlin md

(Town, county, and state)

10. Usual occupation Laborer11. Industry or business Same as Above12. Name Samuel Bowen13. Birthplace Berlin md14. Maiden name Martha E. Bowman15. Birthplace Berlin md16. Informant Mrs Mamie BowenAddress Berlin md17. Burial Date thereof Mar 16 - 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EvergreenLocation Berlin md18. Funeral director James P. StewartAddress Salisbury md19. 3-16- 46 Helen F. Hayward

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1946 at 2309 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw h.....alive on19.....

Immediate cause of death Broken neckDue to Auto accident

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of March 13 '46Where did injury occur? Shawee Worcester md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway 113Means of injury Auto collision Injured at work? yes23. SIGNATURE John L. Riley M.D.Address Shawee md Date signed 3/13/46

M.D. or other

RECEIVED
MAR 16 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

CERTIFICATE OF DEATH

Reg. Dist. No. 03085 351

1. PLACE OF DEATH: *Worcester*
County *Sumner*
City or town *Sumner*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *MD* County *St. Johns*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *502 E. Locust St.*
(If rural give LOCATION)
2(a) If veteran, name war *World War #2* ✓

3. (a) FULL NAME *Harry Preston Gootie* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
6. (b) Name of husband or wife *Olive Gootie*
7. Birth date of deceased (mo., day, yr) *Oct. 22-1915* 6. (c) If alive, give age *37* years
8. AGE: Years *30* Months *5* Days *8* If less than one day
.....hrs.min.

9. Birthplace *Salisbury Maryland*
(Town, county, and state)
10. Usual occupation *Truck Driver for*
11. Industrial business *Capital Banking Corp. 19th St.*
12. Name *Froy Edward Gootie*
13. Birthplace *Stockton Maryland*
14. Maiden name *Bertie M. Cliff*
15. Birthplace *Chincoteague Virginia*

16. Informant *Mrs. Olive Gootie*
Address *502 E. Locust St. Salisbury MD*
17. Burial, cremation, or removal (Which?) *Buried* Date there *April 27th 1946*
(City or town) (County) (State)
Cemetery or crematorium *Wesleyan Cem.*
Location *Salisbury Maryland*
18. Funeral director *Holland & G. Walter R. Holland*
Address *Salisbury Maryland*
19. *4-28* / *46* *LeRoy Smith*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 30th 1946* at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19....., fo..... 19.....
and that I last saw h..... alive on 19.....

Immediate cause of death *Burned*
Due to *Accident*

Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide *Accident* Date of *3/30/46*
Where did injury occur? *Snowed out on*
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) *Highway*
Injury at work? *Yes*

23. SIGNATURE *F. S. McNeil, M.D.*
Address *Besler Md* Date signed *4/1/46*

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 4 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

03086

Reg. Dist. No. 351

1. PLACE OF DEATH: *Worcester*
 County.....
 City or town.....*Newark*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Maryland* County.....*Worcester*
 City or town.....*Newark*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....*70*

3. (a) FULL NAME *Hammond Baby*3. (b) Social Security Number *none*

4. Sex *male* 5. Color or race *Caucasian* 6. (a) Single, married, widowed, or divorced *Single*
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) *March 22 - 1946*
 8. AGE: Years Months Days If less than one day
 hrs. *15* min.

9. Birthplace *Newark, Worcester, MD*
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....*Therman Lockwood*13. Birthplace.....*Maryland*14. Maiden name.....*Hazel Hammond*15. Birthplace.....*Maryland*16. Informant.....*Maggie Hammond*Address.....*Newark, MD*17. (Burial, cremation, or removal, Which?) Date thereof.....*March 23/46*
 (month) (day) (year)Cemetery or crematory.....*Williams*Location.....*Newark, MD*18. Funeral director.....*Heane & Darnley*Address.....*Iron Hill, MD*19. *3/23/46* 19 *46* *Reed Smith*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 22* 19.....*46* at *11:30 P* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 22 19.....*46* to *March 22* 19.....*46*
 and that I last saw him alive on *March 22* 19.....*46*Immediate cause of death.....*prematurity*
 DURATION *15 min*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Robert L. La Mar, M.D.*
 M. D. or otherAddress.....*Snover Hill* Date signed.....*3/23/46*

RECEIVED

MAR 25 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

03087
Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Jessie Noeland

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Charles H. Noeland7. Birth date of deceased (mo., day, yr.) Sept. 1, 1857 8. (c) If alive, give age _____ years8. AGE: Years 88 Months 6 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Berlin W.C. md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name William Dennis13. Birthplace Maryland14. Maiden name Larab Dickman15. Birthplace Maryland16. Informant Mrs. Elias Noeland
Address Berlin md17. Burial Date thereof 3/31/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin md.18. Funeral director Anna B. Burboys
Address Berlin md.19. 3-31 19 46 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 46, at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 46 to March 29 19 46
and that I last saw him or her alive on March 29 19 46Immediate cause of death Coronary thrombosisDue to Generalized arteriosclerosisDue to Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. Pratt, M.D.
M. D. or other _____Address Berlin md Date signed 3/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

APR 5 1946

BUREAU OF

ARTISAN LEBES

RAC COAST

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03088

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin R.T.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin R.T.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John William Hudson

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Amelia HudsonB.(c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) February 18 18838. AGE: Years 63 Months 1 Days 8 It less than one day _____ hrs. _____ min.9. Birthplace Berlin Wor. Co. Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William Hudson13. Birthplace Md.14. Maiden name Rosalia Hudson15. Birthplace Md.16. Informant Mrs. John HudsonAddress Berlin Md.17. Burial Date thereof 3/29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EvergreenLocation Berlin Md.18. Funeral director Ansa A. BurbozeAddress Berlin Md.19. 3-28 46 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him alive on March 25 1946

Immediate cause of death _____

DURATION

Carcinoma of
Liver

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas. R. Law

M. D. or other

Address Berlin Md. Date signed 3-29-46

RECEIVED

APR 1 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-2

CERTIFICATE OF DEATH

Reg. Dist. No. 03089 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Cyrus W. Jarvis Jr.

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Evelyn Jarvis7. Birth date of deceased (mo., day, yr.) Aug. 20 1870 8. (c) If alive, give age _____ years8. AGE: Years 75 Months 6 Days 20 If less than one day _____ hrs. _____ min.8. Birthplace Berlin Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Cyrus W. Jarvis Jr.13. Birthplace Berlin Md.14. Maiden name Esther C. C. C.15. Birthplace Berlin Md.16. Informant Wm. Willie C. C.Address Berlin Md.17. Buried Date thereof 3/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory DovergreenLocation Berlin Md.18. Funeral director Anna B. C. C.Address Berlin Md.19. 3-12- 19 46 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 46 at 7:00 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 19 19 45 to March 10 19 46 and that I last saw him alive on March 10 19 46

Immediate cause of death

Carcinoma of
Prostate

DURATION

2 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. H. C. C. M. D. or other _____Address Berlin Md. Date signed 3/14/46

RECEIVED
MAR 15 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03090

Reg. Dist. No. 351

1. PLACE OF DEATH:

County WorcesterCity or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Sarah Kelly7. Birth date of deceased (mo., day, yr.) April 10 - 18608. AGE: Years 85 Months 11 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Withmans, Virginia

(Town, county, and state)

10. Usual occupation Tailor

11. Industry or business _____

12. Name Unknown13. Birthplace VA14. Maiden name Unknown

15. Birthplace _____

16. Informant Lucie CarterAddress Snow Hill, Md17. (Burial, cremation, or removal, Which?) Burial Date thereof March 27/46

(month) (day) (year)

Cemetery or crematory BaptistLocation Snow Hill, Md18. Funeral director Heame & ThomasAddress Snow Hill, Md

19. _____

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Chronic MyocarditisDue to Generalized arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. S. Jones M.D.Address 144 Berlin RdDate signed 3-27-46

RECEIVED
APR 1 1946
BUREAU U S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

CERTIFICATE OF DEATH

03091

Reg. Dist. No. 350

1. PLACE OF DEATH:

County... Worcester
 City or town... Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 30 years
 Hospital, institution, or street address where death occurred: —
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Worcester
 City or town... Pocomoke City Md
 (If outside city or town limits write RURAL and give nearest town)
 Street No... Clarke Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

John St. Keiser

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Solphia Keiser
 6. (c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) Unknown
 8. AGE: Years 77 Months — Days — If less than one day — hrs. — min.

9. Birthplace Pocomoke Accomac Va.
 (Town, county, and state)

10. Usual occupation Day labor

11. Industry or business —

FATHER 12. Name Unknown

13. Birthplace —

MOTHER 14. Maiden name Mary Ann Keiser

15. Birthplace —

16. Informant Alfred Sautter

Address Pocomoke Va.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof March 31/46

Cemetery or crematory Salim M.E. Cemetery

Location Pocomoke City Md

18. Funeral director Marquette Station

Address Pocomoke Md

19. March 31, 19 46 Anne E. White

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1946 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946, to March 29, 1946

and that I last saw him alive on March 29, 1946

Immediate cause of death Myocardial

degeneration DURATION years

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE E. White

M. D. or other —

Address — Date signed 4-1-46

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

DATE: 4/3/46

SUBJECT: [Illegible]

RECEIVED

APR 3 1946

BUREAU

3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03092

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Richard Lynn Massey

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

October 5, 1942

8. AGE:

Years

Months

Days

If less than one day

3513

hrs.

min.

9. Birthplace

Berlin Worcester md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Charlie Massey

13. Birthplace

Maryland

14. Maiden name

Hilda Jackson

15. Birthplace

Maryland

16. Informant

Mr. Charlie Massey

Address

Berlin md.

17.

Burial

Date thereof

3/22/46
(month) (day) (year)

Cemetery or crematory

Evergreen

Location

Berlin md.

18. Funeral director

Anna A. Penhaze

Address

Berlin md.

19.

3-22
(Date rec'd by registrar)

19.

Helen F. Hayward
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946, at 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Birth 1942 to March 21 1946and that I last saw him alive on March 20 1946

Immediate cause of death

Malignant Tumor of right Kidney

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

13. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

MAR 29 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03093



Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 59 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OR DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1
(If rural, give LOCATION)2.(a) If veteran, name war 1

3. (a) FULL NAME

Olivia Ellen Miller

3. (b) Social Security Number

14. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Charles D. Miller

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 23, 18718. AGE: Years 75 Months 2 Days 4 If less than one day _____ hrs. _____ min.9. Birthplace Princess Anne, Somerset Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Esbury Pusely13. Birthplace Md.14. Maiden name Esley Pusely15. Birthplace Md.16. Informant Mrs Grace Marie KirbyAddress Pocomoke Md.17. Buried Date thereof March 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Salim M. E. CemeteryLocation Pocomoke Md.18. Funeral director Margaret's AssociationAddress Pocomoke Md.19. March 29, 1946 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th, 1946 at 6:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M.Found deceased in bed at 8:00 1946.and that I last saw him Grand-daughter ill. March 24th, 1946.

Immediate cause of death

From indications observed- heart failure. SuddenDue to Arterio-sclerosis and myo-carditis. 5 yearsDue to She had a stroke of paralysis in May 1944.Other conditions Feeling very well when she retired.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R Lee HallAddress Pocomoke City, Md. M. D. or other 3/28/46.
Date signed

RECEIVED
APR 1 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 355

03094

1. PLACE OF DEATH:

County WORCESTER
City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County WORCESTER
City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ELVA MAG MITCHELL

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife GEORGE L. MITCHELL

6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 16, 1894

8. AGE: Years 51 Months 11 Days 20 If less than one day
hrs. min.

9. Birthplace BERLIN WOR. CO. M.D.
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name WILLIAM N. BURBAGE

13. Birthplace BERLIN, MD. R.F.D.

14. Maiden name CERELIA H. BAKER

15. Birthplace WHALEYVILLE MD.

16. Informant MR. G. L. MITCHELL

Address BERLIN, MD.

17. BURIAL Date thereof 3/10/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BUCKINGHAM

Location BERLIN, MD.

18. Funeral director Burns A. Burbage

Address Berlin Md.

19. 3-10 19 46 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 8 19 46 10:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19 46 to March 8 19 46
and that I last saw him alive on March 8 19 46

Immediate cause of death Carcinoma of breast DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE L. M. D. M. D. or other

Address Berlin Md. Date signed 3/10/46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03096

Reg. Dist. No.

355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin RFD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin RFD
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jonah Purnell

3. (b) Social Security Number

4. Sex

male colored

5. Color or race

6.(a) Single, married, widowed, or divorced

8.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

April 13, 1942

8. AGE:

Years

Months

Days

If less than one day

3116

hrs.

min.

9. Birthplace

Berlin W.C. Md.
(Town, county, and state) RFD

10. Usual occupation

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

Sedonia Purnell

15. Birthplace

Berlin Md RFD

16. Informant

Sedonia Purnell

Address

Berlin Md RFD

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/1/46
(month) (day) (year)

Cemetery or crematory

Evergreen

Location

Berlin Md RFD

18. Funeral director

Anna A. Burroughs

Address

Berlin Md

19.

(Date rec'd by registrar)

19.

46 Helen F Hayward
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 29, 1946, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/26/46 1946 to 3-29-46and that I last saw him alive on 3-27-46 1946

Immediate cause of death

Endocarditis
Acute Myocarditis

DURATION

Due to

Pneumonic fever

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Clifford E. Schott

M. D. or other

Address

Berlin MdDate signed 4-1-46

RECEIVED

APR 5 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

03095

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Cornelius C. Duviken

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow6.(b) Name of husband or wife Charles S. Duviken

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 29, 18578. AGE: Years 88 Months 11 Days 14 If less than one day _____ hrs. _____ min.9. Birthplace Berlin Wor. Co. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William H. Jarman13. Birthplace Berlin Md.14. Maiden name Caroline Coard15. Birthplace Berlin Md.16. Informant Mrs. Edward JarmanAddress Berlin, Md.17. Burial Date thereof 3/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Buckley's FarmLocation Berlin Md.18. Funeral director Anna A. GivhageAddress Berlin Md.19. 3-16 46 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1946 at 12 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1 1946 to 3-13 1946and that I last saw her alive on 3-13 1946Immediate cause of death Chronic Myocarditis

DURATION

Due to HypertensionDue to Chronic Int. NephritisOther conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓Date of op. ✓Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of 3-13-46Where did injury occur? ✓
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) ✓Means of Injury ✓ Injured at work? ✓23. SIGNATURE Clifford E. Schott M. D. or otherAddress Berlin Md. Date signed 3-14-46

MARGIN RESERVED FOR BINDING

VS A15 T

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ida M. Richardson

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow
6.(b) Name of husband or wife Henry Richardson
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 9, 1884
8. AGE: Years 62 Months 0 Days 11 It less than one day hrs. min.

9. Birthplace Ocean City, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joshua Farlow

13. Birthplace Maryland

14. Maiden name Annie Mitchell

15. Birthplace Maryland

16. Informant Mr. Joshua Richardson

Address Salisbury, Md.

17. Burial Date thereof 3/22/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin, Md.

18. Funeral director Dwight A. Burhop

Address Berlin, Md.

19. 3-22 46 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1946 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-15 1946 to 3-20 1946 and that I last saw him alive on 3-18 1946

Immediate cause of death Carcinoma of Rectum
DURATION ?

Due to ☒

Due to ☒

Other conditions ☒

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other

Address Berlin, Md. Date signed 3/22/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 29 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19106

03098

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH: Worcester
 County.....
 City or town Snow Hill Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... 70

3. (a) FULL NAME Ronie Smith

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sanders Smith
 7. Birth date of deceased (mo., day, yr.) Unknown 6. (c) If alive, give age 60 years

8. AGE: Years About 60 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Snow Hill, Worcester, Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Charles Dufford

13. Birthplace Maryland

14. Maiden name Jane Taylor

15. Birthplace Maryland

16. Informant Sanders Smith

Address Snow Hill, Md Rural #1

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 28/46
 (month) (day) (year)

Cemetery or crematory Hutch Chapel

Location Snow Hill, Md

18. Funeral director Hearn + Dumas

Address Snow Hill, Md

19. 3/23/46 LeRoy Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946 at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24 1945 to March 21 1946
 and that I last saw her alive on March 21 1946

Immediate cause of death Respiratory Paralysis DURATION 1 day

Due to Cerebral Vascular 4 day

Due to hypertensive Cardio-vascular Renal disease 5 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. L. L. M. M. M. D. or other _____

Address Snow Hill Date signed 3/23/46

RECEIVED

MAR 25 1946

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Diat. No. 03099 350

1. PLACE OF DEATH: Wheat
 County Pocomoke
 City or town Wheat
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war 70

3. (a) FULL NAME Greta Ann Stevenson

3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 2 - 1886 6. (c) If alive, give age _____ years

8. AGE: 60 Years 0 Months 1 Days If less than one day _____ hrs. _____ min.

9. Birthplace Pocomoke (Town) county, and state Wicomico Md

10. Usual occupation Housewife11. Industry or business Own Home12. Name James G. Stevenson13. Birthplace Maryland14. Maiden name Elizabeth C. Heame15. Birthplace Maryland16. Informant Mr. William StevensonAddress Pocomoke17. Burial Date thereof March 5/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory First UnionLocation Pocomoke18. Funeral director LeRoy C. DennisAddress Pocomoke19. March 5 19 46 Anne E. White

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 46 at 946 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 46 to March 3 19 46and that I last saw him alive on March 2 19 46Immediate cause of death Cancer oflung + lymphatic9 cm in 9 cm in 6 cmDue to Cancer of Bladderremained 3 cm ago

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE C. E. WhiteAddress Wicomico M. D. or other _____Date signed 3-4-46

CERTIFICATE OF DEATH

STATE OF MISSOURI, COUNTY OF _____

DECEASED

DECEASED

RECEIVED

MAR 6 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03100

Reg. Dist. No. 355

1. PLACE OF DEATH:

County ShoreCity or town Shore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Shore
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William H Taylor

3. (b) Social Security Number

219-07-7271

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife

5. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

May 24, 1921

8. AGE:

Years

Months

Days

If less than one day

24919

hrs.

min.

9. Birthplace

Berlin, Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

William S Taylor

13. Birthplace

Berlin, Md.

MOTHER

14. Maiden name

Bessie Mae Pate

15. Birthplace

Berlin, Md.

18. Informant

Bessie Mae Taylor

Address

Berlin, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

5/15/46
(month) (day) (year)

Cemetery or crematory

St. Luke's

Location

Berlin, Md.

18. Funeral director

Bessie B. Bessie

Address

Berlin, Md.

19.

(Date rec'd by registrar)

19.

46 Helen F. Hayward
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 13

19.

46 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw deceased alive on

19.

Immediate cause of death

Fractures Skull

Due to

Auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Auto accident

Injured at work?

20. SIGNATURE

John L. Rice, M.D.

M. D. or other

Address

Shore, Md.

Date signed

3/13/46

RECEIVED

MAR 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K)

CERTIFICATE OF DEATH

03131

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town Pocomoke City Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester
 City or town Pocomoke City Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Wheatley
 4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife

Molly Sturgis
 7. Birth date of deceased (mo., day, yr.) December 24, 1895
 8. AGE: Years 50 Months 2 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Pocomoke Worcester Co Md
 (Town, county, and state)
 10. Usual occupation Painter - John Hanger
 11. Industry or business Painting

12. Name Washington Wheatley
 13. Birthplace Worcester Co Md
 14. Maiden name Sarah Catherine (?)
 15. Birthplace Worcester Co Md

16. Informant Walter Wheatley
 Address Pocomoke City Md

17. Burial Date thereof 3/11/46
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Cemetery 1 mile S of Pocomoke City Md
 Location 1 mile S of Pocomoke City Md

18. Funeral director Darvey S. S. S. S.
 Address Pocomoke City Md

19. March 12, 1946 Anne E. White
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 8th 1946 at 10:30 P.M.

2I. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6th 1946, to March 8th 1946

and that I last saw him alive on March 8th 1946

Immediate cause of death Cerebral hemorrhage
measured brain locations DURATION 4 days

Due to fracture of skull 4 days

Due to Bleed as head

Ans. to homicide case

Other conditions Alcohol months

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results Head - low brain compression Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur 6th Street Pocomoke Worcester Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 6th Street

Means of injury Force with hammer Injured at work? No

23. SIGNATURE N.E. Sutorius Md

Address Pocomoke City Md M. D. or other _____

Date signed 3/9/46

RECEIVED
MAR 13 1946
BUREAU U.S.